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Black and Blue: Depression and African American Men

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A B S T R A C T

Depression is a common mental disorder affecting individuals. Although many strides have been made in the area of depression, little is known about depression in special populations, especially African American men. African American men often differ in their presentation of depression and are often misdiagnosed. African American men are at greater risk for depression, but they are less likely to participate in mental health care. This article explores depression in African American by looking at environmental factors, sigma, role, and other unique to this populations, such as John Henryism. Interventions to encourage early screening and participation in care are also discussed.

Depression remains one of the leading disabling and costly illnesses worldwide both directly and indirectly (World Health Organization, 2012). For the purposes of this paper, direct cost includes diagnosis, hospitalization and other examinations associated with depression and indirect cost includes loss of productivity and work related duties to include reduced employment, unemployment and other disabilities due to an impaired emotional state (Xue et al., 2015; Zarogoulidou et al., 2015). Direct cost for depression between 2005 and 2010 rose from $173.2 billion to $210.5 billion (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015). This cost is probably higher due to other physiological diseases associated with depression, such as hypertension, obesity liver disease, and other physical disorders (Hankerson et al., 2011; O'Neil et al., 2012; Whooley & Wong, 2013). Depression is a treatable disorder, and proper primary and secondary interventions can be implemented to help reduce the cost of this illness.

The direct cost of depression has been discussed, but there are also indirect costs associated with depression. Depression has been associated with cognitive dysfunction, such as memory loss, irritability, and loss of concentration (McIntyre et al., 2013). Depression tends to present itself during the most productive period of life: 30–44 years of age (National Institute of Mental Health). An individual can lose up to 27.3 work days per year due to depression associated symptoms (Kessler et al., 2006). Other studies have shown that those who work while suffering from depression are less productive due to decreased energy, less interactive with co-workers, feeling less supported from management, and an overall decreased in the ability to perform tasks at work (Bertilsson, Petersson, Ostlund, Waern, & Hensing, 2013; Sallis & Birkin, 2014). The Bureau of Justice Statistics (BJS) (2006) reported that inmates 24 years or younger had the highest incidents of mental illnesses while incarcerated when compared to older inmates. The same study found that most men arrested with a mental illness were employed up to 1 month prior to their arrest. Unfortunately, very little work has been done to directly address depression in the work place. Two separate systematic reviews on depression in the workplace demonstrated that most interventions focus on stress in the workplace, which is a small component of depression (Dietrich, Deckert, Ceynowa, Hegerl, & Stengler, 2012; Furlan et al., 2012). This contributes to the organizational burden of depression. Therefore, more interventions are needed to address not just stress but other symptoms associated with depression in the workplace. This intervention would indirectly impact productivity.

Although much literature exists on the subject of depression and much progress has been made for the general population, little is known about it in African Americans, especially African American men. Depression in African American men was first brought to light in a study by Gary (1985) who identified the illness in this population and suggested rates of depression are higher in African American men than reported. It was suggested that African American men have unique characteristics that make them more vulnerable to depression and that these factors are often missed by most clinicians. The National Institute of Mental Health's "Real Men. Real Depression" campaign sought to expand the message of depression in men. Other literature also suggests that depression in men may be presented in ways not consistent with what is already known or expected, especially when race is a factor. This could lead to misdiagnosis and ineffective treatment. Due to these factors, the potential for treatment disparities exists (Hankerson, Suite, & Bailey, 2015). Therefore, more work in this area is needed to uncover the multiple layers of depression, especially in African American men.

As with most illnesses, there are disparities among depression in African American men when compared to other racial groups. A report in 1999 from the Surgeon General on mental health suggests that a disparity exists in the reporting and diagnosing of depression in African

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American men. For example, suicide is often associated with depression. The report and other studies suggest a disproportionate rate of suicide among African American men, which is often not diagnosed as suicide but often associate with reckless behaviors (Castle, Conner, Kaukeinen & Tu, 2011; Joe, Baser, Breeden, Neighbors, & Jackson, 2006; Kubrin & Wadsworth, 2009). The standard questions related to suicide may not be appropriate for African American men. A more thorough examination surrounding the circumstances of an injury qualitatively might be more appropriate for African American men.

African American men are typically not diagnosed with depression by professionals until they present in a venue other than a mental health setting, such as homeless shelter and correctional settings where care is limited. Head (2007) refers to this way of diagnosis as the back door method and remains a major means by which depression and other mental illnesses are identified and treated in African American men. The BJS (2006) reported that 56% of state inmates, 45% of federal inmates, and 64% of local jail inmates had a mental illness. Symptoms of depression were reported by 23% of state prisoners and 30% of jail inmates. The BJS does not provide data on specific races and mental illness, but given a large percentage of inmates are African American, it can be assumed that a significant number of them have some sort of mental illness. Inmates in all settings were more likely to have been homeless prior to arrest. Many of these facilities, such as homeless shelters and correctional facilities, are not adequately equipped to address mental illness. Sarteschi (2013) conducted a synthesis of mentally ill offenders in the criminal justice system and found that incarcerated individuals were more likely to encounter conditions such as long waiting time for mental health treatment, lack of mental health providers, neglect due to the ability to differentiate true mental illness from malingering, higher rates of behavioral disturbances, and suicide. The relationship between incarceration and mental illness is strong. There is an assumption that childhood experiences, mental illness and incarceration are highly related (Schnittker, Massoglia, & Uggen, 2012). Specifically, being poor, involved in violence, high school dropout, and being homeless were associated with being incarcerated and having a mental illness (Greenberg & Rosenheck, 2014). Environmental factors will be discussed later. Early identification treatment prior to reaching these back door settings might have an impact on other systems.

Sinkewicz & Lee (2011) reported a higher prevalence of depression in African American men when compared to the general population. This was supported by an extensive literature review conducted by Ward and Mengesha (2013) which demonstrated a high prevalence of depression among African American men. Although there is a high prevalence of depression, African American men are less likely to utilize mental health services (Ward, Wiltshire, Detry & Brown, 2013). This is partially due to the perceptions of mental illness in the African American community (Ward et al., 2013). Individuals are more likely to access their primary care provider initially with vague symptoms, such as fatigue, insomnia, and irritability. Many times depression is less likely to be detected because of these vague symptoms, cultural differences in presentation of symptoms, and lack of culturally qualified mental health providers (Noel & Whaley, 2012). The literature supports more understanding of depression in African American men in order to identify unique presenting symptoms in order to address this disparity in diagnosis and treatment.

ROLE EXPECTATION AND DEPRESSION

A number of structural and contextual factors among African American men make them more vulnerable to depression. These factors center on men's ability to demonstrate and fulfill their expected roles with minimal barriers. These factors can act as a facilitator or barrier to accessing needed resources, especially mental health services as discussed by Franklin (1999) and Anderson (1995). Manhood in African American men is defined by a number of factors, such as family, neighborhood, media and general societal expectation; each having conflicting requirements. This sometimes begins at the time of birth. These expectation can have a significant impact on the mental well-being of African American men as they try to negotiate and meet these different expectations (Castle, Conner, Kaukeinen & Tu, 2011a; Castle, Conner, Kaukeinen & Tu, 2011b; Franklin, 1985, 1999; Hartley, 1974). Many times, these expectations can conflict and affect the physical and mental health of these men (Plowden & Miller, 2000).

African American men are expected to conform to masculine roles while dealing with other social issues such as racism and discrimination. Roles such as dominant, independent and supplier have been identified as significant portrayal of masculinity for men (Plowden & Miller, 2000). Brannon (1976) used terms such as sturdy oak, Big Wheel, and No Sissy Stuff to describe masculinity in men. Other studies have identified similar role identification. When men are unable to function in these roles, they are perceived as less than a man, and it becomes a barrier to them caring for themselves. The literature has also shown that men's inability to live up to their expectations of manhood can act as a barrier to seek care (Plowden, 2000). Earlier studies have shown men, specifically African American men, will access health systems when internal and external conditions are sensitive to their need, and they feel accepted (Plowden & Miller, 2000; Plowden and Thompson-Adams, 2013). Therefore, access to health care can be enhanced by promoting factors that support their expected masculine role.

A number of African Americans come from diverse backgrounds. In addition to conforming to a general societal definition of masculinity, African American men must also negotiate expectations of masculinity from their country of origin or family expectation (Laubscher, 2005). The literature and media suggest African American masculinity as being different from general societal expectations (independence, family, etc.). The literature and social media also work to support cultural expectations of African American men. Many times, African American masculinity is portrayed in a negative way, such as a culture in constant chaos. African American men are also often portrayed as being in a constant struggle for survival. Given these expectation, African American men are often pulled in many direction in an attempt to meet the expectations placed upon them. For many African American men, they are judged based on their external appearance and not their internal value. Living up to the many expectations placed upon them could be the catalyst for stress and other depressive symptoms.

The negotiation of the many masculine expectation creates a sex–role strain for African American men (Pleck, 1981). Earlier studies have shown negative effects associated with sex–role strain, often described as hyper masculinity, increased criminal behavior, aggression, and other socially unaccepted social behaviors (Caldwell, Antonakos, Tsuchiya, Assari & De Loney, 2013; Levant, Stefanov, Rankin, Halter, Mellinger & Williams, 2013; Lincoln, Taylor, Watkins & Chatters, 2011; McCusker & Galupo, 2011; McFarlane, 2013; Oliffe, Kelly, Johnson, Gray, Ogrodniczuk & Galdas, 2010; Roberts-Douglass & Curtis-Boles, 2013; Thomas, Hammond, & Kohn-Wood, 2015; Valkonen & Hanninen, 2013). African American masculinity is often defined in a complex manner and expressed as a development of self and free will, leadership and responsibility, spiritual connection, success, and a bond with others outside of self (Roberts-Douglass and Curtis-Boles, 2013). Venues, such as barbershops, schools, sports arenas, and religious communities, serve as resources to enhance this exchange of values and expectations of the African American male roles (Plowden, 2000). The literature shows that the role of African American men is complex and needs further studying.

ECONOMICS

An essential factor associated with masculinity of any group is socio-economic position. Socioeconomic status involves factors such as education, income, and occupation and has shown to have an impact on an individual's mental well-being. Butterworth, Rodgers and Windsor

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